From: To: 2024429430 10/10/2008 03:08 #806 P. 002/050

		H AND HUMAN SERVICES E & MEDICAID SERVICES			. FORM	): 09/25/20 1 APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE S	0. 0938-039 SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII		COMPL	
		09G037	B. WING_		ng/	C 1 <b>2/2008</b>
NAME OF	PROVIDER OR SUPPLIER	·	ST	REET ADDRESS, CITY, STATE, ZIP COI		12/2000
CMS			3	8815 ALBERMARLE STREET NW WASHINGTON, DC 20008		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF COR		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)		COMPLETIO DATE
W 000	INITIAL COMMEN	TS	W 000			
	A monitoring surve	y was conducted from				
	September 11, 200	8 through September 12, Correction submitted by the				
	facility on May 9, 20	008 served as the focus for	*	Received 10	Foloil	
•	this monitoring surv	/ey. All six of the clients were lased either on the findings of	•	GOVERNMENT OF THE DIS	TRICT OF COLU	MRIA
	the April 2, 2008.su	rvey or after new observations		I DEPARTMENT O	FHEALIN	
	were made that we deficient practices.	re relevant to previously-cited		HEALTH REGULATION A	ADMINISTRATIC ., N.E., 2ND FLO	OR OR
	The findings of the	survey were based on		WASHINGTON, I	J.C. 20002	ļ
	observations, interv	iews with staff in the home				
-	client and administr incident reports	rams, as well as a review of ative records, including				
W 104	483.410(a)(1) GOV	ERNING BODY	W 104		er e	
,	The governing body budget, and operation	must exercise general policy, ng direction over the facility.			•	
			. ,			
2	This STANDARD is	s not met as evidenced by:		. *		*
4	review, the governing	on, interview and recording body exercised general				, j
	policy and operation except in the following	al direction over the facility			· ,	,
	The findings include	:				
	failed to establish po	9.1. The governing body blicies to provide clear to how to proceed if/when a	·	1. Cross reference W14	9.1	10/28/08
. 1	medication nurse fai administration of clie	Is to report timely for the			·	
] 1	failed to establish a p	149.2. The governing body policy that defined the term		2. Cross reference W14	9.2	10/28/08
NONIURY	PIKECI YOK'S OR P <u>ROVID</u> E	BISUPPLIER REPRESENTATIVE SIGNA	TURE	TITLE		VC) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
•		09G037	B. WIN				C <b>2/2008</b>
NAME OF P	ROVIDER OR SUPPLIER			38	EET ADDRESS, CHY, STATE, ZIP CODE 315 ALBERMARLE STREET NW /ASHINGTON, DC 20008		212000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 104	policies, however, of of medications at the would constitute a F	The incident management lid indicate that "administration e wrong time (early or late)" Report Incident.	W	104			
	failed to ensure that abrasions of unknow were reported in act It should be noted to reviewed clients' me of September 11, 20 however, review of an evening nurse has unknown origin (on	to 153. The governing body to unusual incidents, such as wn etiology and red bumps, cordance with facility policies. That the RN reported having edical records on the morning 108. On September 12, 2008, Client #1's chart revealed that ad recorded an injury of September 2, 2008) for which eponding incident report.			3. Cross reference W15	3	10/28/08
	evidence that the go whether the facility I	7368.2. There was no overning body had determined had access to pharmacy lays, Sundays and holidays, to rescriptions.			4. Cross reference W36	8.2	10/28/08
	governing body had medication nurses s 4:00 PM to 4:45 PM medications and/or 8:30 PM for the night evidence of a quality that nurses establish administration scheme	assurance system to ensure head a medications).			5. Cross reference W36	8.3	10/28/08
	Report dated April 4 there had been only the 8:00 AM - 4:00 F	440. The Federal Deficiency, 2008 included findings that one fire drill conducted on PM shift (March 4, 2008) over hs. Following that survey,			6. The QMRP and Resider ager will meet monthly review documentation so fire drill.	and will uch as the	Ì

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		IG	COMPLE	TED	
	į	09G037	B. WII	1G_		09/1	C 2/2008	
NAME OF F	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 8815 ALBERMARLE STREET NW WASHINGTON, DC 20008	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	. (X5) COMPLETION DATE	
W 104	24, 2008; thereby m However, the Septe visit revealed that the another drill on that (more than 90 days evidence that the go implemented a qual monitor the QMRP a responsibility to ens conducted at least of	onducted on this shift, on May leeting initial compliance. mber 12, 2008 monitoring le facility had not conducted shift since May 24, 2008 earlier). There was no	W		Any incomplete fire dril be completed within 48 h		10/30/08	
	The facility must end Therefore, the facility individual clients to of the facility, and as	sure the rights of all clients.  y must allow and encourage exercise their rights as clients s citizens of the United States, file complaints, and the right						
	Based on observation review, one client's f	not met as evidenced by: on, interview and record reedom of movement was ogrammatic justification.						
	AM, Client #1 was of as prescribed. A direct held the gait belt from across the living root. The staff person loci positioned herself scaccess to the door.	008, at approximately 8:10 beerved wearing his gait belt, ect support staff person (S1) in behind as they walked in to the facility's front door ked the dead bolt lock and as to block the client's The staff person informed e client wished to go outside.						

		AND HUMAN SERVICES  & MEDICAID SERVICES					FORM	): 09/25/2008   APPROVED   0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	•	NSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		09G037	B. WIN	G	<del></del>	•	09/1	C 2/2008
NAME OF	PROVIDER OR SUPPLIER		,	STREET AD	DRESS, CITY.	STATE, ZIP CO		
CMS	- · · · · · · · · · · · · · · · · · · ·		-	3815 AL	BERMARLES NGTON, DC	STREET NW		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE ROSS-REFERE	S PLAN OF COR ECTIVE ACTION ENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 125	Continued From pa	ne 3	- W 1	25	<del>-</del>			<del> </del>
77 120	The staff, however, The client persisted reaching for the dea	continued to block the door, in his attempts to go outside, id bolt and trying to unlock it, nued for a few minutes.	VV 1	25				•
	directly next to the fi however, was opaque trying to see through happen if the man was staff replied that he	npted to look out the window ront door. The glass, ie and he quickly stopped it. When asked what might ras allowed to go outside, the 'might run." When asked it sons the client should not go						
·	outside, the staff rep further indicated that during the evening s through the front doo minutes, Client #1 w	blied "he might fall." She t staff took him on walks hift. After trying to exit or for approximately 10 alked back into the living staff holding him by the gait						
	(QMRP) was intervied beginning at approximate there were no recoutside (to either the more likely to walk quere expected to use	Retardation Professional wed later that morning, mately 10:13 AM. She stated strictions on Client #1 going front or back yard). He was wickly, rather than run. Staff a the gait belt whenever the		#1's futur	right to e, staff	go outsi	on Client de. In the trained on ly.	10/30/08
	at all times." She sa take him outside if the depending on the time outside then take him might be if there were after nightfall, or if the for departure to day a confirmed that they to	Id staff "should be at his side id she "would expect staff to at was what he wished e of day, if it was beautiful in for a walk." Exceptions inclement weather, if it was eavy were about to load the van programs. The QMRP book walks in the evenings. at Client #1 refused to go for						
- 1	a walk on the previou	s evening. After she was ervations at the front door						

		AND HUMAN SERVICES  & MEDICAID SERVICES	-			·	FORM	1 APPROVED	)
STATEME	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPL	E CONSTRUCTION	. }	(X3) DATE S	). 0938-0391 SURVEY	1
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUIL	LDING			COMPLETED		
	· 	09G037	B. WIN	iG			C 09/12/2008		
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODÉ	007	12,1200	1
CMS			ĺ		5 ALBERMARLE STREET NW ASHINGTON, DC 20008				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOU E APPRO	LD BE	(X5) COMPLETION DATE	
· W 125	Continued From page	ge 4	W 1	25					1
	was loaded at appro suggested perhaps	imately 8:10 AM, and the van eximately 8:25 AM, she the client's interest earlier e van he was one of the in" that morning.				-			
W 149	review of Client #1's (BSP), dated Novembehaviors of self-injudestruction and aggress BSP did not instruct movement unless he behaviors. Further refailed to show justifice going outdoors with	at approximately 5:35 PM, Behavior Support Plan aber 26, 2007, revealed target urious behaviors, property ression towards others. The staff to restrict his freedom of a displayed maladaptive review of the client's records cation for preventing him from staff supervision.	W 14	49					
	policies and procedu	elop and implement written res that prohibit at or abuse of the client.						_	
	Based on observation review, the facility fail	not met as evidenced by: n, interview and record led to establish and/or esigned to ensure the clients'	·						
	The findings include:				· •	•			
·	ensure that clients re scheduled time, as fo Cross-refer to W368. clients were observed	to implement measures to ceived medications at the ollows:  On September 11, 2008, it between the hours of 3:20 ey were not observed to		re	ne facility will development of the development of	admin	nistrat ewed by		

#806 P. 007/050

CENTE STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) N	JULTI	PLE CONSTRUCTION	FORM OMB NO. (X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BU	ILDIN	G	COMPLE	
	_	09G037	B. WII	NG_	<del> </del>		C 2/2008
NAME OF F	PROVIDER OR SUPPLIER		<del> ,</del>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	,	
CMS				3	815 ALBERMARLE STREET NW		
<u> </u>				V	VASHINGTON, DC 20008	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 149	Continued From page	ge 5	W	149			
	receive their evening according to their Maccords (MARs) we	g medications, which edication Administration ere to be administered at 5:00					
	2:30 PM, interview v	12, 2008, at approximately with the RN indicated that she	-				
· · · · · · · · · · · · · · · · · · ·	outlined how facility	er the facility had a policy that staff should proceed if/when			· •		
		d did not notify their ector of Nursing (DON) was	•				
		hone at 3:05 PM, at which nat the facility was without					
	With respect to the administration of metacility's Incident Ma	edications), review of the					
	September 12, 2008 "Medication Errors"	should be considered a , "thereby generating an	,				·
	unusual incident rep the DON, at approxi she would not conside	ort. Telephone interview with mately 2:30 PM, revealed that der administration of					
	medication error. W clarification, she state	after the designated time as a hearth for further that she would expect					-
	later." Interviews hashe nor the RN had	Iministered "before 2 hours d also revealed that neither been informed that the					
	night before.	d arrived after 7:26 PM the		,			
:	Manager presented a examples of medical "administration of medical" (early or late)." No in	0 PM, the Residential another policy that listed tion errors, which included edications at the wrong time acident report had been administration on the					

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 09/25/2008 FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
· -		09G037	B. WIN	G	C 09/12/2008
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE COMPLETION
W 149	Continued From pa	ge 6	W 1	49	
	ensure that Client # medications, as follows.  a. On September 1 interview with the factors.	2, 2008, at 11:10 AM, cility RN revealed Castellani		The nursing staff and the Medication Employees will additional training about umentation. In the future primary nurse will monit	I receive it doc- re, the cor the
	daily to deter thumb client's July 2008 M on July 17, 26 and 2 the MAR failed to sl that the medication	o Client #5's nails one time sucking. Review of the AR revealed spaces left blank 27, 2008. Further review of now documented evidence had been applied, or an ny the designated spaces had		MAR for documentation or basis.	10/28/08
	orders to be adminis Zyprexa 5 mg every 2008 MAR revealed received these med July 17, 2008. Furth to show documentar	ent #5 also had physician's stered Fluoxetine 20 mg and morning. Review of the July no evidence that the client ications on the morning of her review of the MAR failed tion indicating why the had been left blank.			
	was previously unaw therefore, had not in whether the client ha medications as orde policy stated that if a any reason, the spa-	th the RN revealed that she ware of the missing data and, westigated to determine ad received his prescribed with the facility's medication a medication was not given for the MAR should be ason should be documented			
	ensure that staff (eit support staff) prepar	153. The facility failed to her nursing staff or direct ed incident reports of client ce with facility policies. The		* Cross reference W153.	1 10/30/08

#806 P. 009/050

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	09/25/2008 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		09G037	B. WIN	NG _		09/1	2/2008
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1815 ALBERMARLE STREET NW		
				.ν	VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 7	W.	149			
	monitoring visit reve not reported during	ealed 2 such injuries that were September 2008.					
. •	5. The facility's RN written "Procedure as follows:	failed to implement the For Discarding Medications,"		·	The nursing staff will radditional training on t	he facili	1
	quantity of pills were the toilet bowl. The Interview with the di that the RN had left minutes before the was interviewed by at approximately 5. she had tried flushin commode; however several attempts. Capproximately 6.00 "Procedure For Disc that "in the event the expiredthe nursing medication and writtlabel notify Nursin medication(s) that in promptly." The process with the promptly."	g staff will pull applicable e D/C or expired on the			dures.		10/21/08
W 153	were discovered in that the clients were their day programs r		<b>W</b> 1	153			
	The facility must ens	sure that all allegations of					

#### PRINTED: 09/25/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G037 09/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ΙD (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 153 Continued From page 8 W 153 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of incident reports and review of client records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator and to the State agency. The findings include: On September 11, 2008, beginning at 3:36 PM, incident reports were reviewed in the facility. Review of client records later in the monitoring visit, however, revealed the following: .Staff will be trained on incident 1. On September 12, 2008, at 2:10 PM, review of reporting and the incident man-Client #1's nurse progress notes in the 10/30/08 Medication Administration Record (MAR) book gement policy quarterly. revealed that an evening nurse recorded an injury of unknown origin for which there was no corresponding incident report. The nurse's entry, dated September 2, 2008, indicated that Client #1 had sustained a 1-to-2-inch abrasion surrounded by a 3-inch hematoma to the left side of his face while he was at day program. No further information regarding the source of the injury had

been documented by the nurse, and there was no

corresponding incident report, in accordance with facility policies. The Residential Manager and the

(QMRP) were in the facility at the time the nurse's note was discovered. They both denied prior

evidence that staff had completed a

Qualified Mental Retardation Professional

PRINTED: 09/25/2008

		I AND HUMAN SERVICES  & MEDICAID SERVICES			·		APPROVED .0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED .
	÷	09G037	B. WIN	1G		09/12	2/2008
NAME OF P	ROVIDER OR SUPPLIER		_ <del>_</del>	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CMS					815 ALBERMARLE STREET NW		
	·				VASHINGTON, DC 20008		<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPF  DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
			<del> </del>				
.W 153	1	_	W <sup>2</sup>	153			
	knowledge, the inju their administrator.	lient's injury. To their iry had not been reported to In addition, State agency					
	records had not ref prior to this monitor	lected notification of said injury ing visit.	٠.				
	2 Cross-refer to W	V331.2. On September 11,			2. In the future, all he	alth con-	
_	2008, at approxima	itely 7:00 PM, three dime-sized	•		cerns will be communicate		
	red bumps were ob	served on Client #6's left arm.			nurse in writing.		10/30/08
		al Manager and the QMRP				•	
	were made aware of	at time, nobody knew the					•
		s. The next evening		•			1.
•	(September 12, 20	08), at approximately 5:00 PM,					
	interview with the R	Residential Manager and				,	
		at there had not been an				,	
		pared. There was no evidence tor had been notified					
	immediately of the						
							,
		hat on September 12, 2008,				•	
_		ximately 5:00 PM, review of			•		
	evidence that the h	rogress notes failed to show umps had been brought to the					
	medication nurse's	attention on the previous					
	evening, for assess	ment. In addition, telephone					
		N revealed that neither she				•	
		Nursing had been made aware				*	·.
	humns had been a	e was no evidence that the ssessed by a trained medical				-	
.	professional.	socosed by a damed medical					
,							
	This is a repeat def	īciency.					
	*****	<del></del>		٠.			
	April 4, 2008 cited t	eral Deficiency Report dated the facility's failure to notify of an injury of unknown origin					

#806 P. 012/050

		I AND HUMAN SERVICES			•			FORM	09/25/2008 APPROVED 0938-0391_
STATEMENT	CS FOR MEDICARE  OF DEFICIENCIES  OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUC	CTION		(X3) DATE SU COMPLE	JRVEY TED
		09G037	B. WING	·					C 2/2008
	ROVIDER OR SUPPLIER		5	3815	ALBERMA	, CITY, STATE, Z RLE STREET			
CMS		<u> </u>		WAS		N, DC 20008			,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH	VIDER'S PLAN C CORRECTIVE A EFERENCED TO DEFICIE	CTION SHOU THE APPR	JLD BE	(X5) COMPLETION DATE
W 153	Continued From pa	ge 10	W 15	53			·		
		l) sustained by a resident on						· ,	
W 159	483.430(a) QUALIF RETARDATION P	IED MENTAL	W 15	59	•.	•			
	integrated, coordinate	treatment program must be ated and monitored by a ardation professional.							
	Based on interview Qualified Mental Re (QMRP) failed to a and coordinate the treatment needs, for	s not met as evidenced by: , and record review, the etardation Professional dequately monitor, integrate, health, safety and active or six of the six clients residing nts #1, #2, #3, #4, #5 and #6)							
	The findings includ	e.							-
	ensure that direct s Client #1's freedom maladaptive behav implement restrictive	V125. The QMRP failed to upport staff only restricted of movement if/when lors indicated the need to re controls, in accordance with support plan (BSP).		1.	. Cross	referenc	e W125		10/30/08
	ensure that staff (e support staff) prepa injuries, in accorda monitoring visit rev- not reported to the agencies during Se noted that the QMF	V153. The QMRP failed to ither nursing staff or direct ared incident reports of client noce with facility policies. The ealed 2 such injuries that were administrator and government optember 2008. It should be RP informed of the discovery of at #6's arm on the first day of				referenc		1	10/30/08 10/30/08
	3. Cross-refer to V	/249.1. The QMRP failed to							_

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ND PLAN OF CORRECTION I DENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
	• .	000007	A. BUILDI B. WING		С
	<del></del>	09G037		····	09/12/2008
CMS	ROVIDER OR SUPPLIER	•	ST	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLÉTION
W 159	Continued From pa	ge 11	W 159	9	
	ensure that direct s implemented Client	upport staff consistently #5's BSP.			
		249.2. The QMRP failed to		4. Cross reference W249	10/30/08
-	accordance with his the QMRP indicated Specialist" supervis been updated accor no evidence that a v	4 received 1:1 supports in BSP. Although interview with a recent change to "Acuity ion, Client #4's BSP had not dingly. In addition, there was written job description had define the "Acuity Specialist's" ities.			
	ensure that staff we	252. The QMRP failed to re trained to consistently of Client #5's targeted (thumb		5. Cross reference W252	2 10/30/08
	2008 Plan of Correct the future, the facilit quarterly during each Residential Manage quarterly and provide	440. The facility's May 9, stion included the following: "In y will conduct a fire drill h shift. The QMRP and the r will review fire drill records training on fire drill safety," ate of June 20, 2008. Since		6. Cross reference W104	10/30/08
	one fire drill on the 8 May 24, 2008, there However, findings of monitoring visit reversed Residential Manage compliance.	rvey, the facility documented 3:00 AM - 4:00 PM shift, on by meeting initial compliance. If the September 12, 2008 aled that the QMRP and refailed to ensure sustained			
	•	GRAM IMPLEMENTATION	W 249	9	
	formulated a client's each client must rec treatment program of	disciplinary team has individual program plan, eive a continuous active consisting of needed rvices in sufficient number	. ,		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	COMPLE	TED
• 0		09G037	B. WIN	IG_	<u> </u>	1	2/2008
NAME OF P	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 249		ge 12 pport the achievement of the in the individual program	W2		<ol> <li>The staff will be tra Client #5's BSP. In the staff will be trained qu on all Clients BSP and d behaviors.</li> </ol>	future, arterly	ng 10/30/08
	Based on interview failed to ensure that	s not met as evidenced by: and record review, the facility clients received continuous two of the six clients residing its #4 and #5)					-
· ·		d to consistently implement			· · · · · · · · · · · · · · · · · · ·		
	follows:  Client #5 was obser thumbs on Septembre 8:15 AM. It was not was chipped. He combined the first feet thumb interminutes. Even though the living rowhile he sucked his support staff escorter.	ved intermittently sucking his per 12, 2008, beginning at the did that his right thumb nail ontinued to suck his right, then nittently for approximately five gh there was one staff staff occasionally coming om, they did not intervene thumbs. At 8:20 AM, a direct ed the client upstairs to arture to the day program.					
	Residential Manage BSP to address thus behavior. Review of report dated June 19 that thumb sucking behavioral in nature BSP, dated May 6, 2	:30 AM, interview with the revealed the client had a mb sucking/ nail biting f a dermatology consultation 5, 2008 revealed a conclusion and nail biting were According to Client #5's 2008, staff should observe the king and redirect him when it					

		H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/25/2008 APPROVED 0938-0391	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G037	B. WII	ig_		1	C <b>2/2008</b>	
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
CMS				31	815 ALBERMARLE STREET NW VASHINGTON, DC 20008	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE.	
W 249	Continued From p	эле 13	W	249	-			
** 2-10	•	_ <del>_</del>	• • •	- '	2. The QMRP sent a packa	ge to MA	<b>A</b>	
-		t his fingers or thumb into his	-		for a Behavioral Acuity	in May	,	
		to tell him to stop, instruct him		.	2008. Client #4 will rec	eive add	ic .	
		ind then immediately redirect			tional support once MAA			
	him to do somethi	ng else with his hands.						
25		vever, revealed that staff failed			the behavioral acuity.Cu		1	
	to implement Cliei	nt #5's BSP as written.			the package is being pro			
	0 '00-444				The QMRP:will follow-up	with MAA	-	
		not receiving 1:1 staff support as			monthly re: the status of	the		
•	prescribed in his E	SSP, as follows:			behavioral acuity. The Q	MRP will		
	Free Manuals Office	it #4's BSP, dated November	-		work with the personnel			
		I the following: "He is primarily a			to develop a job descrip			
		and/or others without a 1:1 staff			the "acuity specialist".		10/31/08	
	person at all times				·	•	'	
		ay, night, weekendsanywhere,			•	•		
	anytime danger	to others when he is not					į	
		d by someone such as a 1:1, as	•					
		nore aggressive at these times."					1	
		s included: elopement, physical			,		·	
	aggression, public	masturbation, spitting,		-	·			
Ì	touching others ar	id pulling his hair.						
	On Contombor 11	, 2008, at approximately 6:45	•					
		al Manager stated that 1:1						
		ded when Client #4 went to day						
	program only on t	Monday - Friday. The client					•	
		a designated 1:1 on weekends						
	and weakday avai	nings after the the daytime staff						
		of their shift, reportedly due to						
		On September 12, 2008, at						
, .		RP stated that funding had				•		
		an "Accuity Specialist" who she						
		ng visual observation but not					}	
		o be in immediate proximity to						
		interview, however, revealed				•	,	
•		I not yet begun receiving the						
		m and the client remained						
		uity Specialist" supervision. The						
		Wiedged Client #4's RSP had			,		1.	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDII	NG		2	
· · · · · · · · · · · · · · · · · · ·		09G037	B. WING_			12/2008	
C M S	PROVIDER OR SUPPLIER		;	REET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 249	Continued From pa	ge 14	W 249			<del></del>	
,	not been revised to in level of staff supe	reflect the proposed change ervision.					
٠.	description presente	nat there was no written job ed to outline the specific duties of an "Acuity Specialist."			-		
	This is a repeat defi	ciency.					
	********	·	,		-		
	addressed in the Ap	1:1 staffing needs were ril 4, 2008 Statement of acility's May 9, 2008 Plan of the following:	•				
	hours Monday throu Monday through Sur be sought	ease <his> 1:1 hours from 8 gh Friday to waking hours nday." Additional funds would</his>					
W 252		BRAM DOCUMENTATION	W 252				
	specified in client ind	emplishment of the criteria dividual program plan documented in measurable					
	Based on observation review, the facility fair relative to the accommobjectives was document to the second control of the second con	not met as evidenced by: n, interview and record led to ensure that data splishment of behavioral mented in measurable terms, nts residing in the facility.		_			

To: 2024429430

10/10/2008 03:13

#806 P. 017/050

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PRÖVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUIL	JLTIPLE CON DING	STRUCTION		(X3) DATE SURVEY COMPLETED C		
		09G037	B. WIN	G		··-		2/2008
NAME OF F	PROVIDER OR SUPPLIER			3815 ALB	RESS, CITY, ST ERMARLE STF GTON, DC 20	REET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		EACH CORRECT OSS-REFERENC	PLAN OF CORRECTIVE ACTION SHO CED TO THE APP OFFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 252	Continued From pa	age 15	W 2	52				
	Client #5 was obse thumbs, alternately	49.1. On September 12, 2008, erved sucking both of his y, between 8:15 AM and 8:20 esent on again off again during		Cross	s referenc	ce W249.1		10/30/08
	those 5 minutes. I Manager, at appro that the client had	nterview with the Residential ximately 10:30 AM, revealed a behavior support plan (BSP)				•		
	behaviör. Accordir 2008, staff should whenever observe	humb sucking/nail biting ng to his BSP, dated May 6, document the behavior d. At 1:12 PM, however,	e Se					
W 331	morning revealed ( There was no evid- maintained accura	's ABC documentation for that D incidents of thumb sucking. ence that facility staff te data regarding the frequency b sucking behavior.	W 33	31				
	The facility must pr	rovide clients with nursing ance with their needs.			-			
	Based on observat review, the facility f services for five of	is not met as evidenced by: ion, interview and record failed to provide nursing the six clients residing in the , #2, #4, #5 and #6)						
	PM, review of Residual that on June 10, 20 void; therefore, the been performed. To provide a urine san the lab reports in the	e:  12, 2008, beginning at 4:03 dent #1's lab records revealed 108, he had been unable to requested urinalysis had not the resident did, however, riple on the next day. Most of the record, including those that lune 10, 2008, had been						
DRM CMS-256	67(02-99) Previous Versions			Facility ID: 090	-037	I£ a#	nustion sheet l	0 10-500

#806 P. 018/050

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		09G037	B. WING	S	09/12/2008	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLETIC	N
W 331	(PCP), indicating we results and noting a regarding appropriate of the urinalysis test obtained June 11, 2 dates, initials or oth indicate that the PC	ge 16 y the primary care physician hen he had reviewed the my additional comments the follow-up. However, review t report for the sample 2008 revealed no signatures, er notations that would P had received the results of	W 33	The primary nurse will that all lab results by the PCP. In the fuprimary nurse will remedical records of the on a monthly basis.	are reviewed ture, the view the	08
	telephone that after She checked their rand could not locate urinalysis test result absence of notation that the PCP had not 2: The facility failed	sing was interviewed by noon, beginning at 4:14 PM. ecords in the medical office a copy of the June 11, 2008 is. She further stated that the s on the Jab report indicated by yet seen the report.  I to ensure that nursing staff d bumps on Client #6's left				
	PM, this surveyor of bumps on Client #6 raised center part of those associated wi Residential Manage Retardation Profess were previously una arm. [Note: The cli home from day prog- earlier.] The next evat a approximately 5:0 nurse progress note a nurse had assessal later, the RN was co- said she was previo	2008, at approximately 7:00 oserved three dime-sized red is left arm. There was a feach bump, resembling th bug bites. Both the ir and the Qualified Mental sional (QMRP) stated that they ware of any bumps on his ent and his peers had arrived grams approximately 3 hours wening (September 12, 2008), in PM, review of Client #6's is failed to show evidence that ed the client's arm. A minute ontacted by telephone. She usly unaware of any red Client #6. She then asked if				

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES	-	F	TED: 09/25/2008 ORM APPROVED NO. 0938-0391	
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION (X3) D.	(X3) DATE SURVEY COMPLETED	
		09G037	B. WII	NG	C 09/12/2008	
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	03/12/2000	
CMS ——				3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE	
W 331	they had been on hi contact with this sur Director of Nursing. aware of any bumps earlier (at approximates Residential Manage determined that a nuat or near 7:28 PM tadminister medication that he had assesse According to the Resobserve bumps on Comorning. The client from the facility all at	s head. While maintaining veyor, the RN telephoned the She too had not been made is. During a conversation ately 2:20 PM) with the r and QMRP, it had been urse had arrived at the facility he evening before, to ons. There was no evidence of the client's arm. [Note: sidential Manager, he did not client #6's arm the next and his peers were away fternoon on September 12, //, the client remained out of	W	2. Cross reference W153.2	10/30/08	
	3. Cross-refer to W3 ensure that Medicati (MARs) were accura not been documente July 2008 MAR.  4. Cross-refer to W3 ensure that medicatic accordance with phys September 11 and 12 ensure that evening administered during to (no more than 1 hour PM) designated on the 3-day delay in security prescribed for treating (c) Two medications Client #6 at bedtime with 5:00 PM instead; and	365. Nursing staff failed to on Administration Records tely maintained. Data had d consistently on Client #5's 368. Nursing staff failed to ons were administered in sician's orders. (a) On 2, 2008, nurses failed to medications were the designated time frame before or 1 hour after 5:00 neir MARs. (b) There was a neg medication that was g a boil on Client #2's head, that were prescribed for were being administered at (d) Client #1 did not thic three times daily for 7		Cross reference W149 Cross reference W149	10/28/08	
	days, as prescribed for	or the treatment of a wound.				

#### PRINTED: 09/25/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 09G037 09/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 331 W 331 Continued From page 18 The nursing staff will receive On September 11, 2008, review of incident additional training in nursing reports revealed that in early August 2008, Client documentation and the primary #2 received treatment for a boil on the back of his head. Subsequent review of his medical records nurse will review nurses progress revealed a failure by nursing staff to document 10/28/08 notes on a weekly basis. the condition and/or status of the boil, in accordance with facility policies. On September 12, 2008, at 5:15 PM, review of the facility's Policies and Procedures Manual, revealed a policy titled "Illness/Injury" that requires "daily follow-up by the nurse until the illness/injury is resolved." Nurses had only described the boil sporadically, on 7/29/08, 8/2/08, 8/3/08, 8/4/08 (when antibiotic treatment started), 8/6/08, 8/9/08, 8/15/08 and 8/16/08. Nurses failed to document the status of the illness on other days. There was a note dated 8/17/08 indicating that the antibiotic treatment had been completed. However, the note failed to indicate the status of the boil and the record did not reflect when the boil had actually been resolved. It should be noted that Client #2's record reflected a history or recurring boils. W 365 W 365 483,460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility

The finding includes:

failed to ensure that the individual medication record was accurately maintained, for one of the six clients residing in the facility. (Client #5)

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILI	JILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED				
		09G037	B. WING	G	09/12/2008			
NAME OF P	ROVIDER OR SUPPLIER	J	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION			
W 365	his thumbs on Sep Further observatio this time revealed chipped. He conti- left thumb intermitt minutes, without st	bserved intermittently sucking stember 12, 2008 at 8:15 AM. In of the client's thumbs during the nail on his right thumb was nued to suck his right, then his tently for approximately five caff intervention.	W 36	65 Cross reference W149	10/28/08			
	with the nurse reverthe dermatologist of sucking was probated further review of the report revealed a rapplying Castillani to deter thumb such physician's order (I Paint Mod Liquid (a interview with the paint material paint material).	2008, at 11:10 AM, interview ealed that on June 16, 2008, determined that the thumb ably of a behavioral nature, the dermatologist's consultation ecommendation to continue Paint to his nails one time daily sking. A corresponding PO) documented "Castillani apply to nails daily)." Further orimary RN revealed that the is applied to the client's finger g by a nurse.						
	administration reconurse failed to doc	5's July 2008 medication ord (MAR) revealed that the ument having applied the nis nails on July 17, 26 and 27,						
	interview with the p #5 had POs for Flumg every morning that the client was further interview wi review of the MAR, verify that the clien medications on Jul							
W 368	483.460(k)(1) DRU	G ADMINISTRATION	W 36	58				

#806 P. 022/050

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
09G037	A. BUILDING  B. WING				
NAME OF PROVIDER OR SUPPLIER  C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR CROSS-REFERENCED TO THE APPLICATION CROSS-REFERENCED TO THE APPLICATION CONTROL PROVIDER OF THE APPLIC	OULD BE COMPLETION			
W 368 Continued From page 20 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in compliance with physician's orders, for five of the six clients residing in the facility. (Clients #1, #2, #4, #5 and #6)  The findings include:  1. The facility failed to ensure that evening medications were administered during the designated time frame, as follows:  a. Surveyors were in the facility on September 11, 2008, between the hours of 3:20 PM and 7:26 PM. No client was observed receiving his medications during that period. On the next day, September 12, 2008, at approximately 2:30 PM, the Residential Manager reported that the medication nurse had arrived "just 2 or 3 minutes" after the surveyors had departed the previous evening. Immediate review of the clients' Medication Administration Records (MARs) revealed that 5:00 PM was the time designated	W 368 Cross reference W149	10/28/08			
for evening medications. The RN, who was present during this interview, indicated that she was previously unaware that medications had been passed after 7:26 PM on the night before. The RN immediately telephoned their Director of Nursing (DON), who also stated she was unaware of any late medication administrations in this facility.					

		I AND HUMAN SERVICES				FORM	: 09/25/2008 APPROVED : 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		09G037	B. Wi	NG_		P .	C 2/2008
NAME OF F	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CMS				1 1	3815 ALBERMARLE STREET NW WASHINGTON, DC 20008		.i
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 368	Continued From pa	ge 21	W	368			
	b. At approximatel clients' MARs revea documented the Se medication pass wi	y 2:30 PM, review of the aled that the nurse had eptember 11, 2008 evening thout indicating that he had 2 1/2 hours after the time	:				-
	administering mediconstitute a "med e When asked "how DON said she woul administered no lat designated time. S	v 2:35 PM, when asked if cations beyond 6:00 PM would rror," the DON replied "no." ate would be too late," the d expect medications to be er than 2 hours after the he was then informed that the medication pass began 2 1/2:00 PM time frame.					
,	2008, between 6:13 evening, the medical	ence was held September 12, i PM - 6:56 PM. On that ation nurse had not arrived at ne surveyors' departure shortly					
	3:05 PM, the DON it telephone that the a policy on how they so nurse does not arrive	nat on September 12, 2008, at informed the facility's RN by ingency was without a written should proceed if/when a very within the time period for to, or >1 hour after) for a					
	policy stating that a between 4:00 PM to afternoon (5:00 PM) also stated that a no 8:00 PM and 8:30 PM	noted that the facility had a nurse should be on site 4:45 PM to administer the medications. The procedure urse should be onsite between M for night administration. rd review had not, however, evening (8:30 PM)					

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	APPROVED:
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		09G037	B. WING		1	C 2/2008
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	. :	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 368	administration was designated for a 5:0  2. The facility failed received medication	expected for medications 0 PM administration. to ensure that Client #2 timely for treatment of a boil	W 368	that prescriptions are within 24 hours. In the the QMRP and/ or the Re Manager will ensure all	filled future, sidential orders	·
	indicated that Client back of his head. S boil 2 days earlier (J 2008, the PCP presidally for "folliculitis/ recurrent nature." F 2008 MAR revealed on Monday, August approximately 6:10 land the QMRP both there were any know pharmacy services of filling a new prescription.	note, dated August 1, 2008, #2 had a pus-filled boil on the taff reportedly had noted the July 29, 2008). On August 1, cribed Bactrim antibiotic twice with abcess - draining, seview of the client's August that the Bactrim was started 4, 2008, 3 days later. At PM, the Residential Manager replied "no" when asked if wh difficulties accessing during a weekend, to include thion.		from consultants be forw the nursing office the s so that medication order be filled.	ame day,	10/28/08
	at bedtime, as order physician (PCP), as On September 12, 2 eyes were closed an side while he sat in a much of the next 25 fatigued and/or to be review of Client #6's September 2008 phy included orders to ha Benztropine Mesylat bedtime. According medications were be other medications at	008, at 8:00 AM, Client #6's d his head drooped to the a chair in the living room. For minutes, he appeared sleeping. This prompted a medication regimen. His vsician's orders (POs)		Cross reference W149		10/28/08

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: COMPLE				
·	09G037	B, WING	3	C 09/12/2008		
NAME OF PROVIDER OR SUPPLIER  C M S			STREET ADDRESS, CITY, STATE, ZI 3815 ALBERMARLE STREET N WASHINGTON, DC 20008			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIÉS Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE COMPLE THE APPROPRIATE DAT	TION	
additional medication beyond 5:00 PM. It that the discrepance	none) revealed that no on passes were scheduled in addition, they acknowledged by between administering the 2 of PM instead of bedtime had	W 3	Cross reference W1	10/28	/08	
policies recognized clients might requir According to the posite between 4:00 Fafternoon medication onsite between 8:00 night administration however, that the faestablished a schemedication needs.  4. Client #1 did not times daily for 7 day  On September 12, Client #1's Medicat (MAR) for the montothat he was not adraccordance with his According to the September 1, 2008 dose on September 2, 2008 dose on September 3, 2008 dose on September 3, 2008 dose on September 4, 2008 dose on September 4, 2008 dose on September 5, 2008 dose on September 6, 2008 dose on September 7, 2008 dose on September 8, 2008 dose on September 9, 2008 dose dose dose dose dose dose dose dose	that the agency's written the possibility that some e medications at night. Solicy, the nurse should be on PM to 4:45 PM to administer on. A nurse should also be 0 PM and 8:30 PM for the n. There was no evidence, acility's nursing staff had dule to meet Client #6's treceive an antibiotic three ys, as prescribed, as follows:  2008, at 5:18 PM, review of ion Administration Record th (September 2008) revealed ministered Keflex antibiotic in sphysician's orders (POs). Extember 2008 POs, he was 500 mg by mouth 3 times daily d." Review of the MAR ceived 3 doses of Keflex on He did not receive the noon r. 2, 3 or 4, 2008. Further revealed that he received the ember 5, 6 and 7; however, he on administration on 110, 2008. In total, he missed		In the future, the will ensure a Nurs Medication Employe to administer noon	e or a Trained e is available	3/08	

#806 P. 026/050

		I AND HUMAN SERVICES	· .			FORM	: 09/25/2008 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DE CORRECTION	ICIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			URVEY ETED C
		09G037	B. WING	3 <u> </u>			2/2008
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	i	•
CMS		•			5 ALBERMARLE STREET NW ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 368	Continued From pa	ige 24	W 36	68			
	Residential Manage person who had ini that he received his	up interview with the er revealed that the staff tialed the MAR on the dates s medication at noon was a					
	employee had according program. The Resthat on the 6 days to	Employee (TME). That ompanied him to his day idential Manager confirmed that Client #1 missed the on, there was another staff ho was not a TME.					
	It should be noted to prescribed on Augu #1's August MARs	hat the Keflex was initially ist 29, 2008. However, Client were not in his record and, se date that the Keflex was				·	
W 440	established and ma		W 44	40			
	The facility must he quarterly for each s	old evacuation drills at least hift of personnel.		С	ross reference W104.6		10/30/08
٠.	Based on interview	s not met as evidenced by: and record review, the facility lation drills quarterly on all					
	The finding include:	s:					
	September 12, 200 revealed that for the there had been one	ty's fire drill records on 8, beginning at 4:17 PM, e 8:00 AM - 4:00 PM shift, e fire drill documented on May ras no evidence that another					

#806 P. 027/050

		AND HUMAN SERVICES  & MEDICAID SERVICES	· 	· · · · · · · · · · · · · · · · · · ·	PRINTED: 09/25/2008 FORM APPROVED OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		09G037 .	B. WING			2/2008	
NAME OF F	PROVIDER OR SUPPLIER		38	EET ADDRESS, CITY, STATE, ZIP CODE  15 ALBERMARLE STREET NW  ASHINGTON, DC 20008			
(X4) (D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 440	followed. When int the Residential Mar	ge 25 ucted during the 90 days that erviewed shortly thereafter, lager acknowledged that there onducted on that shift since	W 440				
	This is a repeat def	iciency.					
-	Report included the drill records on Apri was only one fire dr	14, 2008 Federal Deficiency following: "Review of the fire 12, 2008, revealed that there ill conducted on the 8:00 AM - h 4, 2008) for the entire year."					
	May 9, 2008, in whie "In the future, the fat quarterly during eac Residential Manage quarterly and provide	ed a Plan of Correction, dated ch the following was written: cility will conduct a fire drill ch shift. The QMRP and the er will review fire drill records be training on fire drill safety," ate on June 20, 2008.					
	·				·		
·	·						
	-					·	

#806 P. 028/050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HEDO3-0095			V	(X3) DATE SURVEY COMPLETED C 09/12/200				
NAME OF T	DAMAGED AD ALLEST	HFD03-0095	REET ANDRESS OF	DDRESS, CITY, STATE, ZIP CODE				
CMS	ROVIDER OR SUPPLIER	38		LE STREET NW				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COM THE APPROPRIATE DA			
1 000	INITIAL COMMEN	TS	- 1000					
	September 11, 200 2008. The Plan of facility on May 9, 2 this monitoring sur were subject to revindings of the Aprobservations were previously-cited de The findings of the observations, inter and at two day pro	ey was conducted from 28 through September 12 Correction submitted by 208 served as the focus forey. All six of the residenciew, based either on the il 2, 2008 survey or after romade that were relevant efficient practices.  It is survey were based on views with staff in the hor grams, as well as a review instrative records, including	the or its new to	GOVERNMENT OF TH DEPARTMI HEALTH REGULA	E DISTRICT OF COLUMBIA ENT OF HEALTH TION ADMINISTRATION OL ST., N.E., 2ND FLOOR TON, D.C. 20002			
1 090	maintained in a sa and sanitary mann	derior of each GHMRP sh fe, clean, orderly, attractiv	re,	The QMRP will do we through's of the favironment and will maintenance concerntial Manager will the QMRP's walk-the safety.	acility's en- document all rns. The Resid- l follow-up with			
	Based on observation to maintain to	t met as evidenced by: tion and interview, the GH he interior and exterior of d attractive manner.						
	September 11, 200 carpet on the front (3) of the steps. T presented a trip har removed by September 11, 200 carpet on the front (3) of the steps. T	le: g of the monitoring visit, o 08, at 3:20 PM, the green steps had long tears on t he tears were unattractive izard. The carpet had be mber 12, 2008, at 1:30 PM e trip hazard. Interview wi	hree e and en M;					

Health F	Regulation Administra	ation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		HFD03-0095		B. WING _		09/12/2008		
NAME OF F	PROVIDER OR SUPPLIER	111 203-003	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
CMS	NOVIDEN ON OUT LIEN		3815 ALB		STREET NW			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE		
I 090	Continued From pa	ge 1		1 090	·			
	minutes later revea replace it with new	tardation Profession ied that they planned carpet in order to hid crete that that was cr	l to e the					
	observed that the h the second floor ba sharp, jagged edge presented an imme to flush the toilet. T	1, 2008, at 3:50 PM, andle used to flush th throom was broken, The exposed edge diate hazard to anyo he discovery was ma	he toilet in leaving a ne trying ade at the					
	front door, returning the Residential Mar Residential Manage that the handle had he had already infor department. He did	residents were coming from their day prograger and other staff. Findicated that he was broken earlier that damed their maintenary not, however, know paired. The Resident	rams, with The ras aware ay and nce when the	·				
	Manager was inform implement immedia residents' health an instructed staff to perthat particular toilet, use other bathroom immediate threat to abated. The toilet he	ned that the facility measures to ensure to ensure to ensure to ensure the measures to ensure the measurest them in the facility. The safety had therefore andle was replaced grand residents were	nust ire the e, he i using stead to been before					
	AM, the view out of a red recliner chair's yard. The chair's ba and one of the arm Next to the recliner bedroom furniture, v removed from their	, 2008, at approxima the kitchen window r was observed in the ack was broken back rests also was dislod was a wooden piece vith its three (3) draw tracks and placed or niture. The broken f	evealed back wards lged of vers					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		HFD03-0095		B. WING_			.: 2/2008
NAME OF F	PROVIDER OR SUPPLIER	-	STREET AD	DRESS, CITY, STATE, ZIP CODE			
CMS				ERMARLE STON, DC 2	STREET NW 20008	•	. 1
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
1 090	Continued From pa	ige 2		1 090			
,	a kitchen drawer was result of the bloom of	neighbors. At the sai as observed to be mi ade of a large kitcher he drawer (but not pro Residential Manager a led that the broken fo	issing its n knife otruding). a few		<u>-</u>		
	had belonged to for discharged from the furniture had been approximately one had been broken "a	mer resident who ha e facility in June. He out in the yard for (1) week. The kitche a couple of days" befo	nd been said the en drawer ore the				
	observed removing	maintenance person the furniture from the ming. The kitchen dr 0 PM.	e yard				
l 135	3505.5 FIRE SAFE	ΤΥ		I 135	Cross reference W104.6		10/30/08
	Each GHMRP shall order to test the effort (4) times a year	conduct simulated fi ectiveness of the plar r for each shift.	ire drills in n at least				
	Based on interview	met as evidenced by and record review, the ation drills quarterly o	ne facility				, ;
	The finding includes	s:	. ]				
	September 12, 2006 revealed that for the there had been one	y's fire drill records o 8, beginning at 4:17 I e 8:00 AM - 4:00 PM fire drill documented	PM, shift, I on May				
	24, 2008. The May facility back into cormonitoring visit, how sustained compliand that another drill had	24, 2008 drill brough mpliance. The finding vever, revealed the face. There was no evid been conducted dud. When interviewed	nt the gs of this allure of ridence uring the				

#806 P. 031/050

PRINTED: 09/25/2008 FORM APPROVED

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	•	HFD03-0095		B. WING_		1	2/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
				ERMARLE STON, DC 2	STREET NW 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
I 135	Continued From pa	ge 3		l 135			
•		dential Manager there had been no d shift since May 24, 20		-			
	This is a repeat def the Office of the Fir	iciency and will be re e Marshall.	eferred to				
. ,	*********	- *******		-			·
; ;	Report included the drill records on Apri was only one fire dr	l 4, 2008 Federal De following: "Review l 2, 2008, revealed t ill conducted on the h 4, 2008) for the er	of the fire hat there 8:00 AM -				
	May 9, 2008, in whi "In the future, the fa quarterly during eac Residential Manage quarterly and provide	ed a Plan of Correction the following was actility will conduct a find shift. The QMRP or will review fire drill be training on fire drill ate on June 20, 2006	written: ire drill and the records I safety,"				
l 160	3507.1 POLICIES A	ND PROCEDURES	.	1 160			
	describing the polici follow which shall be to meet the needs of	have on site a writte les and procedures i e as detailed as is no if each resident serv each staff member.	t will ecessary ed and	, :			_
	Based on interview GHMRP failed to ha	met as evidenced by and record review, the ave written policies a re sufficiently detaile s.	he nd				
	The findings include	): :				•	
W 5	1. The facility failed	to develop a policy	to ensure				

PHVE11

#806 P. 032/050

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Health R	<u>legulation Administra</u>	ation						<del></del>	<del></del> 1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		A. BUILDIN	IPLE CONS	TRUCTION		COME	SURVEY PLETED C
		HFD03-0095	•	B, WING			09	09/12/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIF	CODE	· .	<del></del>	
CMS				ERMARLE TON, DC 2		NW	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		ACH CORE	R'S PLAN OF COI RECTIVE ACTION RENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
I 160	Continued From pa	ge 4		I 160	Cross	referè	ence W149		10/28/08
	that residents recei scheduled time, as	ved medications at the follows:	ne						
	observed between PM. They were no evening medication	2008, residents were the hours of 3:20 PM t observed to receive s, which according to	and 7:26 their their					·	
,	to be administered 12, 2008, at approx with the RN indicate	stration Records (MA at 5:00 PM. On Sep timately 2:30 PM, inte ed that she did not kr had a policy that outl	tember erview now		,		•		
	facility staff should nurse did not arrive did not notify their s Nursing (DON) was	proceed if/when a me at the designated tire supervisor. The Direct interviewed by telep ime she indicated that	edication ne, and ctor of phone at				·		
	administration of m facility's Incident M September 12, 200 "Medication Errors" "Reportable Incident re the DON, at approximat she would not medications 1 hour medication error. Varification, she stamedications to be a later." Interviews his she nor the RN had medication nurse him.	the issue above (late edications), review of an agement Policy on 8, at 2:19 PM, reveat should be considered." Thereby generating port. Telephone intext after the designated When asked for furthed that she would eadministered "before ad also revealed that ad arrived after 7:26	f the led that ed a rview with realed on of time as a er expect 2 hours t neither the						
	Manager presented	20 PM, the Resident I another policy that I ation errors, which in	isted						

PHVE11

#806 P. 033/050

PRINTED: 09/25/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	· · · · · · · · · · · · · · · · · · ·	HFD03-0095		B. WING _		09/1	2/2008
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
CMS	•			SERMARLE S STON, DC 2	STREET NW 10008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
l 160	"administration of n (early or late)." No	ge 5 nedications at the wro incident report had b e administration on t	een -	I 160	Cross reference W149		10/28/08
	a. On September 1 interview with the far Paint was applied to daily to deter thumber resident's July 2008 blank on July 17, 26 review of the MAR evidence that the market interview of the market interview.	I to ensure that Resided medications, as ped medications, as I2, 2008, at 11:10 AM acility RN revealed Coordinates Review of Box Review of Rev	follows:  //, astellani one time the ces left her nented applied,				
	orders to be admini Zyprexa 5 mg every 2008 MAR revealed received these med July 17, 2008. Furt to show documental	sident #5 also had p stered Fluoxetine 20 morning. Review of no evidence that the lications on the morn her review of the MA tion indicating why the had been left blank.	mg and f the July e resident ing of R failed				
	was previously unautherefore, had not in whether the resident medications as order policy stated that if any reason, the spatencircled and the reconthe reverse side.		data and, nine rescribed nedication t given for ald be umented				
ealth Bodille		79. The facility failed ther nursing staff or d					

PHVE11

#806 P. 034/050

PRINTED: 09/25/2008 FORM APPROVED

(X3) DATE SURVEY

	OF CORRECTION	IDENTIFICATION NUI		A BUILDIN	IG	- COMPLE	1.
	·	HFD03-0095		B. WING _		1 ,	2/2008
NAME OF P	ROVIDER OR SUPPLIER		3815 ALB	DRESS, CITY, ERMARLE TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
l 160	support staff) prepa resident injuries, in policies. The monit	ge 6  red incident reports accordance with fac oring visit revealed 2 or reported during Se	ility 2 such	I 160	The nursing staff wi additional training ation of illnesses a In the future, the p will review individu records to ensure al	on document- and injuries. orimary nurse als medical	
I 180	3508.1 ADMINISTF	RATIVE SUPPORT		·I 180	are being addressed	and monitore	10/28/08
-		provide adequate ort to efficiently mee nts as required by the				· .	
	Based on observati review, the governing	met as evidenced by on, interview and red ng body exercised go nal direction over the ing areas.	cord eneral				
	The findings include	e:	•				
	failed to establish p direction to staff as medication nurse fa	60.1. The governing olicies to provide cle to how to proceed if alls to report timely for sidents' medications.	ear When a or the	-		÷	***
	Citation W149.2. T establish a policy the "medication error." policies, however, confidence at the	ederal Deficiency Re he governing body f lat defined the term The incident manag did indicate that "adn he wrong time (early Reportable Incident.	ailed to gement ninistration or late)"				
	failed to ensure that abrasions of unknot were reported in ac-	79. The governing t unusual incidents, wn etiology and red cordance with facilit hat the RN reported	such as bumps, y policies.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	DENTIFICATION NOT	MBEK.	A. BUILDING B. WING			C 09/12/2008	
		HFD03-0095			THE SORE		32000	
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE			
CMS 3815 Al WASHII			3815 ALBE WASHING	RMARLES TON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM?	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
I 180	morning of Septem 12, 2008, however revealed that an evinjury of unknown of which there was report.	' medical records on aber 11, 2008. On Se , review of Resident a vening nurse had recorigin (on September s no corresponding in	eptember #1's chart orded an 2, 2008) ncident	I 180	Cross reference W160  The Director of Nursi		10/28/08	
	Citation W368.2. monitoring visit find securing medication treating a boil on Fino evidence that the determined whether pharmacy services holidays, to include	Federal Deficiency Re The September 12, 2 dings revealed a 3-da on that was prescribe desident #2's head. The governing body had ar the facility had account on Saturdays, Sundays, Sun	2008 ay delay in d for There was ad ess to lays and ions.		weekend/ holidays on be responsible to use macies on weekends/ h ensure medication ord ated within 24 hours.	other phar olidays &	-	
	nurses implemente	body failed to ensure ed a medication adm resident needs, as in	inistration					
	revealed that Resi physician's orders Paxil 20 mg and B administered at be however, those madministered along PM on a routine, or RN and the Direct revealed that no a were scheduled be they acknowledge administering the instead of bedtime previously.	2, 2008 monitoring vident #6's September (POs) included order enztropine Mesylate editine. According to edications were being with other medicational medication eyond 5:00 PM. In a d that the discrepance had not been address.	r 2008 ers to have 1 mg his MARs, g ions at 5:00 es with the ephone) passes ddition, by between 0 PM essed		Cross reference W149		10/28/08	
		revealed that the age	ency's				<u> </u>	
Jaalth Dani	dation Administration					•		

#806 P. 036/050

Health R	Regulation Administra	ition	-		<u> </u>	<del></del>	<del></del>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SL COMPLE	TED
	•	HFD03-0095		B. WING_			2/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	•	
CMS				ERMARLE TON, DC 2	STREET NW 20008	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
I 180	Continued From page 8			I 180			į
	written policies reco some residents mig night. According to be on site between	ognized the possibility on the policy, the nurse 4:00 PM to 4:45 PM on medications and/o	ns at should to				
	between 8:00 PM a administration. The quality assurance s	nd 8:30 PM for the nere was no evidence ystem to ensure that ation administration	ight of a nurses				
	that the governing I quality assurance s and Residential Ma ensure that fire drill quarterly on each s  7. The governing be RN implemented the Discarding Medicate	ody failed to ensure e written "Procedure ions" policy, as follov	ed a QMRP to least that the For		6. Cross reference W104,	6	10/30/08
	quantity of pills wer the bowl of the toile near the laundry ro- dissolve. Interview indicated that the R approximately 10 m arrived. The RN wa later that afternoon She confirmed that Tylenol down the counsuccessful after: September 12, 200 review of the facility Medications" reveal medication has expapplicable medication	2008, at 3:25 PM, a see observed at the bot in a half-bathroom order. The pills had be with the direct support of the supproximately 5:10 she had tried flushin order of the supproximately 6 several attempts. Or 8, at approximately 6 several attempts. Or 8, at approximately 6 several of the support of the	ttom of located gun to ort staff rveyors ephone 15 PM. og expired the was 15:00 PM, iscarding that a off will pullerspired on				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	•	BERTHIOTHOU		A. BUILDIN	G	- 1 0	; . [
		HFD03-0095		B. WING_		T.	2/2008
NAME OF S	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
,					STREET NW		
CMS			WASHING	TON, DC 2	0008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	(X5) COMPLETE DATE	
I 180	Continued From page 9			F 180			
	promptly." The pro-	needs to be picked u cedure did not, howe an alternative dispo	ever,	-			
	were discovered in that the residents w their day programs	hat at the time that the commode, staff vere due to return how momentarily. Indeed to and some individual toilet in question.	indicated me from d, they				
l 291	Each record shall be kept current, dated, and signed by each individual who makes an entry.  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each resident's record was kept current, for two of the six residents in the GHMRP. (Residents #1 and #5)		l 291	The primary nurse w health related docu them in the medical primary nurse will	ments and fil book. The	e ·	
				ents medical record	•	10/28/08	
	The findings include	e:					- :
	4:35 PM, review of revealed a seizure experienced a seizure However, there was Activity Report form Further review of the nurse progress note indicating that he (the Activity Report form onsite interview with Retardation Professing explain why the record. At 5:00 PM	12, 2008, at approxing Resident #1's medic chart indicating that is ure on August 7, 200 is no corresponding So in the resident's receive medical chart reverse, dated August 8, 20 in the Russe) had seen a for that event. A sunthe Qualified Mentasional revealed that so form was not in the telephone interview.	al records ne had 8. Seizure cord, saled a 008, a Seizure absequent al she could medical v with the				
ealth Descri	KN revealed that sr ation Administration	ne did not have the S	eizure	<u> </u>	<u> </u>		<u> </u>

#806 P. 038/050

Health F	Regulation Administra	ation		<del></del>			
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		HFD03-0095		B. WING_			2/2008
NAME OF P	ROVIDER OR SUPPLIER	1			STATE, ZIP CODE		
CMS			3815 ALBI WASHING	ERMARLE TON, DC 2	STREET NW 20008	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
I 291	Continued From pa			I 291			
,	Activity Report form should always be k	n in question, and sa tept in the residents	id forms chart.	٠.			
. •	4:45 PM, review of that the Medication	12, 2008, at approxir Resident #1's record Administration Reco	d revealed   ord (MAR)				
	records. At 5:00 P RN revealed that s	igust 2008 was not in M, telephone intervie he did not have the l	w with the MARs in				
	question, and in ge kept in the residen	eneral, MARs should ts' chart.	always be				10 (00 (00
·	interview with the r 2008, the dermato	12, 2008, at 11:10 Al nurse revealed that o logist determined tha g was probably of a b	n June 16, it Resident		Cross reference W149		10/28/08
	nature. Further re- consultation report continue applying 6	view of the dermatok revealed a recommo Castellani Paint to his	ogist's endation to	·		. •	
	documented "Cast	thumb sucking. A sician's order (PO) ellani Paint Mod Liqu rther interview with th	uid (apply				
	RN revealed that to to the resident's fir nurse. Review of	he Castellani Paint w nger nails every morr Resident #5's July 20	vas applied ning by a 008 MAR				
	revealed that the n applied the Castell 17, 26 and 27, 200	iurse failed to docum ani Paint to his nails 8 and there was no	ent having on July				
	administered.	icating that it had no	t been	1 202			
I 292	3514.3 RESIDENT			1292			
	Each record shall the requirements of 6-1972 (1989 Rep	include, but not be lir of D.C. Law 2-137, D I. Vol.).	nited to, .C. Code §			·	
leader D	Based on interviev	t met as evidenced by and record review,	y: the	,			
TATE FOR	lation Administration			6889	PHVE11	If continuat	ion sheet 11 of 23

10/10/2008 03:20

#806 P. 039/050

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE				TRUCTION		COMPLE	
•				A. BUILDIN B. WING _	ig	<del>,</del>		(	
		HFD03-0095						09/1	2/2008
NAME OF P	ROVIDER OR SUPPLIER			DRESS, CITY,					
CMS				ERMARLE TON, DC 2		NW .			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(E	PROVIDER'S PL ACH CORRECTIV SS-REFERENCE DEF	VEACTION SHO	OULD BE	(X5) COMPLETE DATE
1 292	Continued From pa	age 11		1 292					
	include Seizure Ac	naintain resident reco tivity Report forms, V ords and/or Incident	ledication		Cross	reference	<b>√1</b> 291		10/28/08
	forms, in accordan	ce with facility policie idents of the facility.	s, for						
	The findings includ	le:							
	6-1972)	, Section 7-1305.12 (							
	maintained and sh professional perso	for each customer s all be readily available ns and to the staff wo volved These recon	e to orkers						
	include: (8) A medication h	story and status;							
		.3 and I291 above.	(formorly						-
	6-1972)	′, Section 7-1305.12 ( for each customer s		,			,		
.	maintained and sh professional perso	all be readily available ns and to the staff wo volved These recor	e to orkers			· · .			
•	(13) A description accident in the faci	of any extraordinary i ility involving the cust aff member noting pe	omer, to		Cross	reference	e W153		10/28/08
,	knowledge of the in source of informati	ncident or accident of ion, including any rep ustomer's mistreatme	r other orts of	,					
• •	See Citations I379							_	
1 379	3519,10 EMERGE	NCIES		1 379				-	
	each GHMRP shall	eporting requirement Il notify the Departme				· .			
lealth Regu	lation Administration								•

#806 P. 040/050

Health R	<u>Regulation Administra</u>	ation				<del></del>	<del></del>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
	<u> </u>	HFD03-0095		THE COLUMN	STATE, ZIP CODE		2/2008
C M S	ROVIDER OR SUPPLIER	·	3815 ALB		STREET NW	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
1 379	Continued From pa	ge 12		1 379			
	unusual incident or interferes with a resarrangement, well to places the resident be made by telephotollowed up by writt	lities Division of any event which substantisted in the substantisted in the substantial s	itially are, living way ition shall shall be			- 48 (1) - 10 (1) - 10 (1)	
:	twenty-four (24) ho	urs or the next work	day.				
	Based on interview review of resident rensure that all injur	met as evidenced by , review of incident re ecords, the GHMRP ies of unknown origired to the Department	eports and failed to n were				
,	The findings include	e:					
· -	incident reports we	2008, beginning at 3 re reviewed in the fac records later in the nated and the nated at the following:	cility.				
	Resident #1's nurse Medication Administrevealed that an ev of unknown origin for corresponding incidents	12, 2008, at 2:10 PM, e progress notes in the stration Record (MAR ening nurse recorder or which there was not appear. The nurse 2008 indicated the	ne R) book d an injury o se's entry,		Cross reference W153.	. <b>1</b> **.* *	10/30/08
	#1 had sustained a surrounded by a 3-i of his face while he further information injury had been doo there was no evider corresponding incident	, 2008, indicated that 1-to-2 inch abrasion inch hematoma to the was at day program regarding the source cumented by the nurs nce that staff had pre- lent report, in accord e Residential Manage	e left side No of the se and epared a ance with				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NUM		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		HFD03-0095	•	B. WING_		L L	2/2008
NAME OF F	ROVIDER OR SUPPLIER		-		STATE, ZIP CODE		
CMS				SERMARLE STON, DC 2	STREET NW 0008	· · · · · · · · · · · · · · · · · · ·	· · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL .	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1 379	Continued From pa	ge 13	, ,	1 379	·		
	(QMRP) were in the note was discovered denied prior knowle They acknowledged reported to their add Department of Heal	etardation Professions facility at the time the d by surveyors. They dge of the resident's I that the injury had n ministrator or to the th. DOH records did f said injury prior to the	ne nurse's y both injury. not been				
	2008, at approximated bumps were obtained. Immediately, I and the QMRP were observations. At the cause of the bulk (September 12, 200 interview with the R QMRP revealed that	/331.2. On Septemb tely 7:00 PM, three d served on Resident # both the Residential te made aware of the at time, nobody presemps. The next evenion, at approximately esidential Manager at there had not been ared, in accordance with the secondance of the secondance	ime-sized #6's left Manager ent knew ing 5:00 PM, and				
	beginning at approx Resident #6's nurse show evidence that to a nurse's attentio interview with the RI	·. —	iew of d to a brought none er she				
	Previously, the State April 4, 2008, cited the DOH immediate		notify was				

#806 P. 042/050

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
	•	UEDAS SOS		A. BUILDIN B. WING_		09/1	2/2008
NAME OF F	200/1050 00 00000 (50	HFD03-0095	STREET AD	DRESS CITY	STATE, ZIP CODE	03/1	212000
CMS	PROVIDER OR SUPPLIER		3815 ALE		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
I 379	Continued From pa	age 14		1 379			
	resident was desci	2008 incident report, to be as being non-refied more than 24 hours of the country	sponsive.				
	dated April 4, 2008 notify their adminis	deral Deficiency Repo , cited the facility's fa trator of an injury of t rehead) sustained by ary 11, 2008.	ilure to ınknown				
. 1 401	3520.3 PROFESS PROVISIONS	ON SERVICES: GEN	NERAL	1401	Cross reference W331	÷ .	10/28/08
	and evaluation, inc developmental levi services, and servi	ees shall include both luding identification o els and needs, treatm ces designed to prev ther loss of function b	f ent ent				
	Based on observate review, the GHMR services for five of	met as evidenced by ion, interview and red P failed to provide nu the six residents resi ents #1, #2, #4, #5 ar	ord rsing ding in				
	The findings includ	e:			·		
	PM, review of Resi that on June 10, 20 void; therefore, the been performed. If provide a urine san the lab reports in the were achieved on a signed and dated by (PCP), indicating w	12, 2008, beginning a dent #1's lab records 008, he had been una requested urinalysis he resident did, howen ple on the next day, he record, including the lune 10, 2008, had bey the primary care plant he had reviewed any additional comme	revealed ble to had not ever, Most of lose that een existed the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDI	•	(X3) DATE S COMPL	
		HFD03-0095		B. WING	<u> </u>		12/2008
NAME OF F	ROVIDER OR SUPPLIER	1	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
CMS			3815.ALB		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
I 401	of the urinalysis terobtained June 11, dates, initials or off indicate that the Potthe urinalysis.  The Director of Nutelephone that afte She checked their and could not local urinalysis test resulus absence of notatio that the PCP had result to the potter of the pott	age 15 ate follow-up. However treport for the samp 2008 revealed no signer notations that worker that received the resing was interviewed trecords in the medicate a copy of the June lits. She further statems on the lab report in the report of the seen t	le natures, ald results of l by	I 401	Cross reference W331		10/28/08
	were previously un arm. [Note: The rearrived home from hours earlier.] The 2008), at approxim Resident #6's nurse show evidence that resident's arm. A recontacted by teleph previously unaware on Resident #6. Ston his head. White surveyor, the RN te	solinal (QMRP) stated aware of any bumps of esident and his peers day programs approximately 5:00 PM, review e progress notes failed to a nurse had assessed in the later, the RN whone. She said she was of any red bumps of the then asked if they a maintaining contact elephoned the Director and not been made averaged.	on his had kimately 3 mber 12, r of ed to ed the vas vas oserved had been with this				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		HFD03-0095		B. WING_			2/2008
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CMS				ERMARLE : STON, DC 2	STREET NW 0008	·	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL .	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
I 401	Continued From pa	ge 16		1 401			. 1
	approximately 2:20 Manager and QMR a nurse had arrived PM the evening bet medications. There assessed the resident to the Residential Moumps on Resident The resident and hi facility all afternoon of 6:56 PM, the resifacility, and therefor 3. Cross-refer to For Citation W365. Nur Medication Administ accurately maintain	e was no evidence thent's arm. [Note: Adlanager, he did not of #6's arm the next ms peers were away fron September 12, 2 dent remained out of re unavailable for versing staff failed to extration Records (MA ed. Data had not be	ential mined that ear 7:28  eat he had ecording observe norning rom the 1008. As of the rification.] eport nsure that IRs) were een				
	documented consis 2008 MAR.	tently on Resident #	5's July		Cross reference W149	•	10/28/08
	Citation W368. Numedications were a with physician's ord and 12, 2008, nurse evening medication the designated time before or 1 hour after MARs. (b) The securing medication treating a boil on Remedications that we at bedtime were beinstead; and, (d) ReKeflex antibiotic threprescribed for the treatment of the securing and the se	ederal Deficiency Re- rsing staff failed to end dministered in accor- ers. (a) On Septem es failed to ensure the swere administered frame (no more that er 5:00 PM) designal ere was a 3-day delanthat was prescribed esident #2's head. (de ere prescribed for Re- ing adminnistered at esident #1 did not rece ee times daily for 7 de eatment of a wound.	nsure that dance aber 11 lat during in 1 hour ted on by in d for c) Two esident #6 5:00 PM ceive lays, as				
		at in early August 200					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	BER:	X2) MULT A. BUILDIN B. WING _		TRUCTION			eted C
· · ·	HFD03-0095			DT.17F 71D	2005		09/1	2/2008
NAME OF PROVIDER OR SUPPLIER  C M S		STREET ADDRES 3815 ALBERI WASHINGTO	MARLE	STREET				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	։ՍԼԼ, ի բ	ID PREFIX TAG	(E)	PROVIDER'S PL ACH CORRECTI SS-REFERENCE DEF	VE ACTION S	HOULD BE	(X5) COMPLETE DATE
back of his head. Some dical records revisite to document the boil, in accordant September 12, 200 facility's Policies and revealed a policy tith requires "daily followillness/injury is reso	ed treatment for a boil Subsequent review of vealed a failure by nur ne condition and/or stance with facility policie 8, at 5:15 PM, review d Procedures Manual led "Illness/Injury" that w-up by the nurse unti-	on the his sing atus of s. On of the t il the	101	Cross	referenc	e W331		10/28/08
8/2/08, 8/3/08, 8/4/0 started), 8/6/08, 8/9 Nurses failed to do illness on other day 8/17/08 indicating the had been completed indicate the status of	sporadically, on 7/29/0 08 (when antibiotic tre 1/08, 8/15/08 and 8/16 cument the status of the s. There was a note of that the antibiotic treated. However, the note of the boil and the receive boil had actually bee	atment /08. he dated ment failed to ord did	,					
It should be noted to reflected a history of	hat Resident #2's reco or recurring boils.	ord						
and assistance to re the resident 's Indiv  This Statute is not a Based on interview failed to ensure that continuous active tre	provide habilitation, to esidents in accordance ridual Habilitation Plar met as evidenced by: and record review, the	raining e with n. e facility e six	122					
and #5) The findings include	•						ī	

#806 P. 046/050

PRINTED: 09/25/2008 FORM APPROVED

H <u>ealth</u>	Regulation Administra	ation				<u> </u>	<u> </u>		
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL <sup>-</sup>		STRUCTION	. <del>.</del>	ļ	LETED
	•	HFD03-0095		B. WING			<del></del>		C 1 <b>2/2008</b>
NAME OF	PROVIDER OR SUPPLIER	<u>,</u>	STREET AD	DRESS, CITY,	STATE, ZI	P CODE ·		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
CMS	•	-		SERMARLE STON, DC		NW		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLEACH CORRECTIVES S-REFERENCE DEF	/E ACTION SHO	OULD BE	(X5) COMPLETE DATE
1 422	Continued From pa	nge 18		I 422			-		
	Resident #5's beha follows:	vior support plan (BS	SP), as		Cross	reference	W249.1		10/30/08
	his thumbs on Sept 8:15 AM. It was no was chipped. He c his left thumb interr minutes. Even thou present, with other through the living ro while he sucked his support staff escort	bserved intermittently tember 12, 2008, begated that his right thur ontinued to suck his nittently for approximate there was one staff occasionally coloom, they did not intest thumbs. At 8:20 All ad the resident upstarture to the day programmer.	ginning at mb nail right, then nately five aff ming revene lairs to						
	Residential Manage BSP to address thu behavior. Review of report dated June 1 that thumb sucking behavioral in nature BSP, dated May 6, resident for thumb sit occurred. If he purmouth, staff were to come to them and him to do something Observations, hower	2:30 AM, interview with revealed the resident revealed the resident revealed the resident revealed and revealed and revealed and revealed and revealed revealed and redirect revealed that steem #5's BSP as written revealed revealed that steem #5's BSP as written revealed r	ent had a and sultation conclusion dent #5's eserve the him when b into his ruct him edirect						
	Even though Reside November 26, 2007 is primarily a danger without a 1:1 staff po are unpredictable	, included the following to himself and/or ot erson at all times b	ng: "He hers ehaviors	·	Cross	reference	W249.2	·	10/30/08

PHVE11

#806 P. 047/050

PRINTED: 09/25/2008 FORM APPROVED

Health F	Regulation Administra	ation			<u> </u>		·
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		UED03 000E		B. WING_		00/4	
NAME OF F	ROVIDER OR SUPPLIER	HFD03-0095	STREET ADD	DESS CITY	STATE, ZIP CODE	09/1.	2/2008
MAINE OF F	ROVIDER OR SUPPLIER		-	-			
СМ(\$ 			WASHING		STREET NW 0008	···	. ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1 422	Continued From pa	ge 19		1 422			
	someone such as a aggressive at these included: elopemen	ot properly redirected 1:1, as he may beco times." Targeted be t, physical aggression ng, touching others a	ome more ehaviors n, public	:			
	PM, the Residential staffing was provided day program only, or resident remained weekends and weekends and weekends to the september 12, 2008	2008, at approximate Manager stated that d when Resident #4 in Monday - Friday. Without a designated kday evenings after the signed-off of their selack of funding. Or 3, at 12:19 PM, the Communication of the communication of the selack of funding.	vent to The 1:1 on the the shift,				
	"Acuity Specialist" wisual observation be in immediate proximinterview, however, not yet begun receive and the resident ren Specialist" supervisi acknowledged Resident	nad been secured for thom she described aut not was not requirable to the resident. Frevealed that the facting the new funding named without 1:1 or on. The QMRP also dent #4's BSP had not proposed change in	as having ed to be further illity had stream "Acuity ot been				
	description presente duties and responsil Specialist."  This is a repeat define	ciency.	ific				
	been addressed in the	and 1:1 staffing need ne April 4, 2008 Fede Citation W249, and S	eral -				

PHVE11

Health R	<u>legulation Administra</u>	ation				<del></del>	<del></del>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION  G	(X3) DATE S COMPLE	ETED
	<u> </u>	HFD03-0095		<u>.   </u>	<del></del>	09/1	2/2008
NAME OF P	ROVIDER OR SUPPLIER		3815 ALB		STATE, ZIP CODE STREET NW 0008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE.  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
I 422	May 9, 2008 Plan o following: "The facil hours from 8 hours	Citation I422. The fa f Correction, included ity will increase <his Monday through Frid lay through Sunday."</his 	d the > 1;1	1 422			
1 500	3523.1 RESIDENT	S RIGHTS		1 500			· 
	that the rights of resprotected in accord	lence director shall e sidents are observed ance with D.C. Law 2 applicable District an	and 2-137, this		Cross reference W125		10/30/08
	Based on observati review, one residen	met as evidenced by on, interview and rec t's freedom of mover rogrammatic justifica	ord nent was			. •	
-	The findings include	e: .		٠.			*
	AM, Resident #1 was belt, as prescribed. (S1) held the gait be across the living room. The staff person loop positioned herself saccess to the door, the surveyors that to outside. The staff, the door. The resid to go outside, reach	2008, at approximate as observed wearing. A direct support state the facility's from the facility from the facility for the facility for the dead both the stalemate continuation.	his gait ff person ey walked nt door. ck and ident's ormed o go o block attempts and				
	The resident then a	ttempted to look out	the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER OF THE PROPERTY OF THE PROVIDER OF	R/CLIA MBER:	(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION  3	(X3) DATE S COMPLE (	TED
AME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
MS.			3815 ALB		TREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5)- COMPLE DATE
	however, was opaqitrying to see through happen if the man vistaff replied that he there were other reago outside, the staff further indicated that during the evening sthrough the front do minutes, Resident #room, with the same belt from behind.  The Qualified Mental (QMRP) was intervious beginning at approximated that there were the was more likely the was more likely the was more likely the wasted that the resider what he wished do if it was beautiful out it was beautiful out it was after the waster, if it was after about to load the varion of the waster of the was	to the front door. The and he quickly stone it. When asked who was allowed to go our "might run." When a second the resident should be asked to the staff took him on we shift. After trying to ear for approximately to walked back into the staff holding him by all Retardation Professewed later that morn imately 10:13 AM. So we no restrictions on either the front or batto walk quickly, rather eated to use the gait ent was walking and she at all times." She is to take him outside if there were included in the pending on the time to take him outside if the pending on the time to take him outside if the she was informed that the she was informed that the she was informed that the she was informed the front door had be AM, and the van was 5 AM, she suggested is interest earlier was was one of the first p	opped nat might tside, the asked it nould not II." She valks exit 10 he living v the gait ssional ing, she Resident ack yard) er than belt staff said she ithat was e of day, or a walk ement were y ey took d that the d that en at loaded d s "going	1500	DEL IGIERO I)		

#806 P. 050/050

THE CONTRACTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095		(X2) MUL A. BUILDI B. WING		-	SURVEY LETED C 12/2008
VAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	, STATE, ZIP CODE		12/2000
C M S 3815 ALB				BERMARLE STREET NW BTON, DC 20008			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
I 500	review of Resident (BSP), dated Nover behaviors of self-inj destruction and agg BSP did not instruct movement unless h	a, at approximately 5 #1's Behavior Supponber 26, 2007, reveaurious behaviors, proression towards other staff to restrict his fine displayed maladapreview of the resider by justification for pro-	:35 PM, ort Plan aled target operty ers. The reedom of otive nt's	1 500			
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